ST. JOSEPH'S CHILDREN'S HOME
P.O. Box 1117 (307) 532-4197 (307)532-5921 Torrington, WY 82240
Fax: (307) 532-8405 or (307) 532-4024

St. Joseph's Children's Home

1419 Main Street
P.O. Box 1117
Torrington, WY 82240

TO WHOM IT MAY CONCERN:

Thank you for your referral regarding a placement at St. Joseph's Children's Home.

Enclosed you will find an Admission Application for our facility. We would appreciate your assistance in completing the documents needed for admission as soon as possible and faxing or mailing them to us on a timely basis. If you are faxing the copy to us, please mail the original as well.

If the child has been in previous placements or received prior mental health services, would you please fill out a separate release of information for each agency or facility, with the entire address and your signature witnessed. This will help in obtaining previous information that will be valuable in our admission process, insurance authorizations and treatment planning.

If the child is not placed at St. Joseph's, please feel free to keep this application for future use. If you have any questions, please do not hesitate to call us at 307-532-4197 FAX 307-532-4024

Thank you for your prompt attention.

Ronda Meyer

Ronda Meyer
Executive Director

Enclosures

DO NOT RETURN THIS PAGE

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Information requested for Pre-Admission Review:

Psychiatric evaluations
Psychological evaluations
Therapy notes
Pre-dispositional Report
MDT Minutes
Medical records for prior psychiatric hospitalizations
Discharge summaries from prior residential/hospital placements
School records: grades, attendance, disciplinary reports, Individual education Plan (IEP)

Note: If above documents are not available please complete a release of information for each provider/ facility requesting information be sent to St. Joseph's Children's Home. This form can be sent/faxed directly to the facility/provider or to St. Joseph's for distribution. (Release of information forms may be downloaded from the admission packet)

Financial/Insurance Information

Title XIX number (Medicaid) (When Medicaid is the payment source a Psychiatric Evaluation recommending PRTF level of care with 30 days of placement is required for admission. The evaluation must be completed by a Board Certified Child/Adolescent Psychiatist)
Private Insurance Card Legible photocopy of front and back of card, social security number, home address and date of birth of primary card holder. Check your benefit plan to see if it includes residential treatment level of care.

Documents and Forms for Admission include:

- **Admission Application (**Signature Required)
- **Consent and Authorization** (Signature Required)
- **Restraints and Seclusions** (Signature required to verify that you were informed)
- **Professional Disclosure Statement** (Signature required verifying that you were informed)
- **Notice of Information Practices Acknowledgement** (Signature required to verify that you received the information)
- **Authorization of Release of Information-** (Signature required **and witnessed)**
- **Child Behavior Checklist (CBCL)** (Will be sent separately)
- **Social History (**to be completed by parent)
- **Permission for Visitation** (Signature required)
- **Consent for Religious Activities** (Signature required)
  Informed Consent for Telehealth Consultations (Signature required)
- **Treatment Involvement for Parent/Family** (Signature required)
- **Suggested Clothing List** (No signature required) Yours to keep.

A two week supply of medications, a copy of the child's birth certificate, insurance cards, and a copy of the child's social security card must be brought along on admission day if not submitted previously.

Please complete the forms and return to St. Joseph's Children's Home as soon as possible. All forms must be submitted prior to admission. If you have questions or want further clarification on use/purpose of any of the forms, contact:

Director of Admissions
P.O. Box 1117
Torrington, WY 82240
Telephone: 307-532-4197
FAX: 307-532-4024

No child will be discriminated against because of race, sex, color, national origin, age, sexual preference or handicap.

DO NOT RETURN THIS PAGE

ADMISSION APPLICATION

CONSENT AND AUTHORIZATION

The undersigned authorize placement of _____
Child's Name
at St. Joseph's Children's Home and consents to the following conditions regarding treatment and care of the resident by St. Joseph's Children's Home:

1. Provide assessment and treatment for psychiatric, psychological, emotional, and behavioral methodologies, which are normal and customary practice. St. Joseph's contracts for psychiatric services provided by a Board Certified or Board Eligible Psychiatrist. The psychiatric services are provided via telehealth and on site.
2. Allow physical intervention and/or placement in a locked quiet room, when used in accord with St. Joseph's Children's Home policies and procedures.
3. Allow a physical examination upon admission and medical care by the physician(s) of St. Joseph's Children's Home choice, including vaccination, emergency care, and other curative or preventive procedures.
4. Allow St. Joseph's Children's Home to authorize emergency medical services.
5. Transport the resident within the state or across state lines for program and/or other treatment purposes.
6. Process the resident for admission by conducting a search of the resident and his/her possessions, and restrict certain personal items considered non-therapeutic to the treatment program. Consent to acquire information from the resident and parent/guardian, photograph resident for identification purposes, and to limit contact by persons not approved by parents and/or legal custodian.
7. Allow the resident to be recorded/filmed for the purpose of internal security, staff training and resident treatment ONLY.
8. Allow the resident to receive treatment by a clinician during their training, while under the supervision of a licensed clinician.
9. Allow St. Joseph's Children's Home to use or disclose your child's protected health information (PHI) for treatment, payment, and health care operations.

Consent denial: If you choose not to provide consent for any of the above please cross out that item and initial.

Signature Instructions:	
1.	If placement is by a social agency or Court Order, a representative from the agency that has legal custody must sign below.
2.	If this is a private placement, a parent or legal guardian must sign.
3.	If the placement is through a school district, parent or legal guardian AND a representative from school district must sign.

I hereby attest that I am the parent/legal guardian/official representative of the resident and possess full/legal rights to sign the above Consent and Authorization.

Signature_____ Title/relationship:_____Date:_____

Name of Agency (If applicable): _____

Signature_____ Title/relationship:_____ Date:_____

Name of Agency (if applicable):_____

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ADMISSION APPLICATION

Complete and sign this form.

IDENTIFYING INFORMATION

Resident Name: _____ DOB _____

Current Placement _____ SS# _____

REFERRAL

Referral Agency: _____ Telephone: _____ FAX: _____

Address: _____ City: _____ State: _____ ZIP: _____

Contact Person: _____ Extension: _____ email: _____

LEGAL STATUS: ___CHINS ___Delinquent ___Neglect ___Voluntary

If applicable: Court District: _____ Telephone: _____ Judge: _____

Address: _____ City: _____ ZIP: _____

GAL/Child's Attorney _____ Telephone _____

Address _____ City _____ ZIP _____

County/District Attorney _____ Telephone _____

LEGAL GUARDIAN INFORMATION (Provide legal documentation)

Name: _____ Address: _____ Phone: _____

Relationship to child: _____

FAMILY INFORMATION

Father: _____ Address: _____ Phone: _____

Mother: _____ Address: _____ Phone: _____

PAYMENT SOURCE:

____Medicaid #_____ ___Private Insurance_____ Policy # _____

Name of School District: _____ School District Placement: (Y) / (N)

Contact Person _____ Telephone _____

Comments: _____

Completed by (Print) _____

Signature: _____ **Date** _____

Relationship/Legal Status to Resident: _____

SIGNATURE REQUIRED

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PERMISSION FOR VISITATION

Resident's Name:_____ Date:_____

Please indicate authorized persons to visit and/or make and receive calls while at St. Joseph's Children's Home. Please indicate yes by marking a check in the visitation and telephone calls columns.

Name	Relationship	Visitation	Telephone Calls

Please list specifically any person(s) the resident is not to have any contact with while at St. Joseph's Children's Home.

Name	Relationship

_____ _____
Signature of Parent/Legal Guardian or Placing Agency Date

SIGNATURE REQUIRED

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CONSENT FOR RELIGIOUS ACTIVITIES

NAME OF RESIDENT:_____

I/We understand that non-denominational services are held in the campus Chapel at St. Joseph's Children's Home. Attendance is encouraged and voluntary.

St. Joseph's Children's Home will make every effort to honor requests concerning religious counsel and/or participation by the above named resident's church denomination.

Check One: ___ I/We grant permission for our child to attend non-denominational services.
____ I/We request _____

_____

_____ _____

Parent/Legal Guardian Signature Date

SIGNATURE REQUIRED

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RESIDENT: _____

RESTRAINTS AND SECLUSIONS

St. Joseph's Children's Home recognizes the importance and the responsibility for providing a therapeutic and safe environment for all children. Residents will sometimes engage in behavior that places themselves and others in a situation that threatens their safety. Imminent threats or attempts to hurt themselves, threats or attempts to hurt others, and intense behavior that incite others to engage in threatening unsafe behavior may require physical intervention by the staff.

When an unsafe situation occurs it may be necessary to place the child in a physical hold until they are able to manage their behavior. If unsuccessful, it also may be necessary to place the child away from other residents in a room where they are isolated until they have better management of their behavior. It may be necessary to lock the room to maintain this isolation.

Residents are encouraged to utilize a quiet area or room on a voluntary basis to assist with regaining self-control as a preventative measure. If the resident is unwilling to take this responsibility, it may be necessary for staff to intervene.

When a restraint or seclusion placement is necessary, the use and procedures are closely monitored and reviewed. An order from a Licensed Independent Practitioner (Psychologist, Therapist or Registered Nurse) is required for any restraint /seclusion intervention.

If the child requires more than one hour to regain self-control, a Licensed Independent Practitioner is required to meet with the individual in person. If the child has been isolated in a seclusion room, every effort is made to help the child end the need for the isolation and rejoin the community as soon as there is no longer imminent danger to self or others. All staff are extensively trained in the use of de-escalation techniques and the administering of holds that have a minimum risk of hurting the child.

Every effort will be made to prevent physical or psychological injury to the child in the event that a restraint or seclusion placement is required. The safety of the child and others are of primary importance. Past abuse and physical limitations are considered to ensure minimum risk for physical or psychological trauma.

The parent/legal guardian will be notified of the time, reason, and outcome in a timely manner when a restraint and/or seclusion placement is initiated. Whenever prudent, family members may be involved in helping to reduce or eliminate the need for restraint or seclusion procedures.

Concerns may be addressed according to St. Joseph's Grievance Policy and Resident's Bill of Rights as outlined and provided to you in the St. Joseph's Parent Handbook.

I have been informed of the philosophy and use of restraints and seclusions by St. Joseph's Children's Home and concur with the interventions when required under the circumstances stated above.

Parent/Legal Guardian: _____
(Print)

Signature: _____ **Date:** _____

SIGNATURE REQUIRED

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INFORMED CONSENT FOR TELEHEALTH CONSULTATIONS

For convenience and cost-efficiency, behavioral health care services are available by two-way interactive video communications and/or by the electronic transmission of information. Referred to as "telemedicine" or "telehealth," this means that you may be evaluated and treated by a health care provider or specialist from a different location. St. Joseph's contracts for psychiatry services provided by a Board Certified or Board Eligible Psychiatrist. The psychiatric services are provided on St. Joseph's campus and through telehealth communication. Since this is different than the type of consultation with which you are familiar, you must certify that you understand and agree to the following:

1. The consulting health care provider or specialist ("Specialist") will be at a different location from me. A physician or other health care provider ("Presenting Practitioner") will be at my location with me to assist in the consultation.
2. The Presenting Practitioner may transmit or share electronically details of my medical history, examinations, x-rays, tests, photographs or other images with the specialist who is at a different location.
3. Details of my medical history, examinations, medications, x-rays, and tests will be discussed with the specialist who is at a different location.
4. I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, the consultant and Presenting Practitioner. I will give my verbal permission prior to additional personnel being present.
5. Video recordings may be taken of the telehealth consultation, after I have given my written permission prior to recording.
6. The Presenting Practitioner for whom the on-site examination or treatment is performed will keep a record of the consultation in my medical record. The Specialist shall also keep a record of the consultation.

Noting all the above, I understand that my participation in the process described (called "telemedicine" or "telehealth") is voluntary.

RELEASE OF INFORMATION: All existing laws regarding access to your medical information and copies of your medical records, including the Health Insurance Portability and Accountability Act (HIPAA) and apply to this telehealth consultation. Additionally, dissemination of any patient identifiable images or information from this telehealth interaction to researchers or other entities shall not occur without your consent.

I further understand that I have the right to:

1. Refuse the telehealth consultation, or stop participation in the telehealth consultation at any time.
2. Limit any physical examination proposed during the telehealth consultation.
3. Request that the Presenting Practitioner refrain from transmitting my information if I make the request before the information is transmitted
4. Request that nonmedical personnel leave the room(s) at any time.
5. Request that all personnel leave the room(s) to allow a private consultation with the off•site specialist(s).

I acknowledge that the health care providers involved have explained the consultations in a satisfactory manner and that all questions that have asked about the consultations have been answered in a manner satisfactory to me or to my representative. Understanding the above, I consent to the telehealth process described above.

_____ _____
Child's Name DOB

_____ _____
Parent/Guardian Signature Date

_____
Relationship

An exact copy of this release is as valid as the original.
SIGNATURE REQUIRED

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, agree to allow
(Parent/Guardian)_

_____
(Agency/Individual **must be completed)**

to release confidential information on _____D.O.B._____
(Child/Resident)

for the purpose of **continuing care, evaluation, and treatment.**

This information is to be released to: St. Joseph's Children's Home
Address: P.O. Box 1117
Torrington, Wyoming 82240-1117
Telephone: 307-532-4197
FAX: 307-532-4024

To the Attention of: Health Information Specialist

I authorize the following information to be released:

( ) Initial Evaluation/Social History and Preliminary Diagnosis ( ) Recent or Final Treatment Reviews
( ) Discharge Summary ( ) Unit Progress Notes ( ) Therapy Progress Notes
( ) Psychological Screening and/or Evaluation ( ) School Progress Notes ( ) Other:
( ) Physical Exam ( ) Aftercare Plan ( ) Other:
( ) Education Assessment

This information will be sent in the following format:
__Written __Verbal __Electronic __Other _____

I understand the child's records are protected under Federal and State Laws, confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken on it. This consent expires automatically twelve (12) months from the date signed unless revoked in writing earlier.

If a drug or alcohol client: I make this consent upon the promise that all disclosures made pursuant to the authority granted by this consent shall be accompanied by a written notice which states as follows:

> "This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR, part 2) prohibit you from making any further disclosure of it without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose."

The information I authorize for release may include records which may indicate the presence of substance abuse or communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome.

I further acknowledge that the information to be released was fully explained and this consent is given of my own free will.

_____ _____
Resident/Client **Date**

_____ _____
Legal Guardian **Date**

_____ _____
Witness **Date**

An exact copy of this release is as valid as the original.

SIGNATURE AND WITNESS REQUIRED

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, agree to allow
(Parent/Guardian)_

_____
(Agency/Individual **must be completed)**

to release confidential information on _____D.O.B._____
(Child/Resident)

for the purpose of **continuing care, evaluation, and treatment.**

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I further acknowledge that the information to be released was fully explained and this consent is given of my own free will.

_____ _____
Resident/Client **Date**

_____ _____
Legal Guardian **Date**

_____ _____
Witness **Date**

An exact copy of this release is as valid as the original.

SIGNATURE AND WITNESS REQUIRED

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Fax: (307) 532-8405 or (307) 532-4024

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, agree to allow
(Parent/Guardian)_

_____
(Agency/Individual **must be completed**)

to release confidential information on _____D.O.B._____
(Resident)

for the purpose of **continuing care, evaluation, and treatment.**

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I further acknowledge that the information to be released was fully explained and this consent is given of my own free will.

_____ _____
Resident/Client **Date**

_____ _____
Legal Guardian **Date**

_____ _____
Witness **Date**

An exact copy of this release is as valid as the original.

SIGNATURE AND WITNESS REQUIRED

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PROFESSIONAL DISCLOSURE STATEMENT

Dear Parents/Guardians:

Therapists at St. Joseph's Children's Home offer mental health services to youth with mental health or behavioral problems that are so severe the child cannot be maintained in a less restrictive environment. Youth must be ambulatory and physically and emotionally capable of participating in St. Joseph's residential program. While no child will be discriminated against because of race, sex, color, national origin, or age, the following conditions may fall outside the accepted range of our treatment program:

- Acute psychiatric instability requiring 24-hour medical services.
- Severe mental disability.
- Active physical health problems requiring 24-hour medical and/or nursing care and supervision.

Therapists, Psychologists and Psychiatrists at St. Joseph's Children's Home adhere to the Code of Ethics of the professional organization designated for their discipline, e.g. the American Counseling Association, the American Association for Marriage and Family Therapy, the National Association of Alcoholism and Drug Abuse Counselors, the National Association of Social Workers, the American Psychological Association, and the American Psychiatric Association, and strongly agree that sexual intimacy with a client is never appropriate. Therapy and treatment issues are confidential. Disclosure of treatment issues and progress will be provided only for those persons or agencies that are legally entitled to such, unless you sign a specific release for information to be provided.

As of March 1, 1999 Wyoming has implemented a privileged communication statute. This law states that, when involved in legal proceedings (civil, criminal or juvenile) clients retain the right to privacy, unless any of the following specific circumstances exist:

a) abuse or harmful neglect of children, the elderly or disabled or incompetent individuals is known or reasonably suspected

b) the validity of a will of a former client is contested.

c) information related to counseling is necessary to defend against a malpractice action brought by a client

d) an immediate threat of physical violence against a readily identifiable victim is disclosed to the counselor

e) in the context of civil commitment proceedings, where an immediate threat of self-inflicted harm is disclosed to the counselor

f) the client alleges mental or emotional damages in civil litigation or his/her mental or emotional state becomes an issue in any court proceeding concerning child custody or visitation

g) the patient or client is examined pursuant to a court order

h) In the context of investigations and hearings brought by the client and conducted by the board, where violations of this act are at issue. Information that is deemed to be of a sensitive nature will be inspected by the board and the board shall determine whether or not the information will become part of the record and subject to public disclosure.

As the Parent/Guardian of _____, I have read and understand this information. I understand that I can obtain a current listing of clinicians from www.stjoseph-wy.org, calling 307-532-4197 or via e-mail to info@stjoseph-wy.org.

Signature of responsible party: _____ Date: _____
Witness: _____ Date: _____

This disclosure statement is required by the Mental Health Professions Licensing Act.
Wyoming Mental Professions Licensing Board, 2001 Capitol Avenue, Room 104
Cheyenne, Wyoming, 82002 307-777-3628, Fax 307-777-3508

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NOTICE OF INFORMATION PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my child's protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my child's treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Information Practices containing a more complete description of the uses and disclosures of my child's treatment information. I understand that St. Joseph's Children's Home has the right to change its Notice of Information Practices from time to time and that I may contact St. Joseph's Children's Home at any time at the address above to obtain a current copy of the Notice of Information Practices.

I understand that I may request in writing that you restrict how my child's protected health information is used or disclosed to carry out treatment, payment or health care operations. I also understand St. Joseph's is not required to agree to my requested restrictions, but if the organization does agree then you are bound to abide by such restrictions.

Child's Name _____D.O.B: _____

Parent/Guardian Signature _____

Date

Relationship to Child _____

OFFICE USE ONLY

I attempted to obtain the parent/guardian signature acknowledging receipt of the Notice of Information Practices, but was unable to do so as documented below:

Reason:	
Signature:	Date:

SIGNATURE REQUIRED

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Treatment Involvement for Parents/Family

We are pleased you have chosen to place your confidence in the treatment services offered at St. Joseph's Children's Home. By doing this we have now become partners, working together, to assist your son or daughter in making meaningful changes. You and your family have probably wanted these changes to occur for a long time and have maybe become frustrated with previous attempts to get this accomplished. The process of helping another human being emotionally heal can become extremely demanding on us emotionally, socially, physically and financially.

We both want your child to have a better life! Our treatment team is committed to do everything possible that encourages positive growth and effective change. After working with hundreds of children and their families for over eighty years, as well as reading what researchers have repeatedly said about successful residential treatment, a major conclusion is drawn: We have to create a solid partnership! While it's a simple formula, 'work together', it is also the strongest predictor of how successful our treatment services will be for any child we serve. It's not enough for a boy or girl to do well in our environment at Saint Joseph's if they then begin to falter once they are discharged. We want to help provide treatment that creates enduring types of change.

All of us; you, your child and his or her treatment team at Saint Joseph's have to work hard and together in order to get the best results possible. Insurance companies, judges, social workers and special educators are also well aware of this need for a partnership between residential programs and parents. They do everything within their power to promote us working together.

We are inviting your willingness to begin and complete this journey together by making a commitment to take on the following responsibilities:

- Parents will participate in monthly treatment review meetings that are designed to discuss recent progress, adjust the treatment plan if necessary, and provide encouragement for your child to continue to work hard at making meaningful changes.

- Parents will participate in weekly family therapy for a minimum of 60 minutes per week. These sessions, by virtue of the family's distance from St. Joseph's, may typically occur by phone or by Skype, if the family prefers and has capability for Skype. The 60 minutes per week is a requirement of the Wyoming Department of Health, Medicaid Division. Scheduling of family sessions and identification of the participants will be arranged each week directly with the child's therapist.

- Parents will attend face-to-face family therapy sessions on-site at St. Joseph's whenever possible to arrange. The face-to-face family sessions will be arranged in advance directly with child's therapist.

- At least once during their child's stay, parents are strongly urged to attend the Common Sense parent training held at St. Joseph's on a quarterly basis. It is desirable and recommended that parents attend more than one parent training whenever possible.

We have read and commit to the outlined responsibilities:

_____ _____
Parent Signature Date

_____ _____
Parent Signature Date

*Please provide your email address below to access your child's documents via our web-based Patient Portal. If you wish to opt out of our web-based Patient Portal please send your request to jgaul@stjoseph-wy.org within 15 days of admission.

____ Web-based Patient Portal (email address) _____
*You will receive an email providing instructions to help you get set up upon admission.

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Notice of Information Practices to Protect the Privacy of Your Child's Health Information

Understanding Your Child's Mental Health Record Information

THIS NOTICE DESCRIBES HOW MEDICAL AND TREATMENT INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time your child visits any healthcare provider, including admission to a residential treatment facility, the provider makes a record of your child's visit. Typically, this record contains your child's health history, current symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment.

This information, often referred to as your child's medical or clinical record, serves as a:

- Basis for planning your child's care and treatment.
- Means of communication among the many health professionals who contribute to your child's care.
- Legal document describing the care your child received.
- Means by which you or a third-party payer can verify that your child actually received the services billed for.
- A tool in medical education.
- A source of information for public health officials charged with improving the health of the regions they serve.
- A tool to assess the appropriateness and quality of care your child received.
- A tool to improve the quality of healthcare and achieve better patient outcomes.

Understanding what is in your child's health records and how this information is used helps you to:

- Ensure its accuracy and completeness.
- Understand who, what, where, why, and how others may access your child's health information.
- Make informed decisions about authorizing disclosure to others.
- Better understand the health information rights detailed below.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

St. Joseph's may *use* or *disclose* your child's *protected health information* (*PHI*), for *treatment, payment, and health care operation* purposes with your *consent.* To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your child's health record that could identify your child.
- *"Treatment, Payment and Health Care Operations"*
  – *Treatment* is when we provide, coordinate or manage your child's health care and other services related to your child's health care. An example of treatment would be when we consult with another health care provider, such as your child's family physician or another provider.
  – *Payment* is when St. Joseph's obtains reimbursement for your child's healthcare. Examples of payment are when St. Joseph's discloses your child's PHI to your child's health insurer to obtain reimbursement for your child's health care or to determine eligibility or coverage.
  – *Health Care Operations* are activities that relate to the performance and operation of St. Joseph's practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

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- "*Use*" applies only to activities within St. Joseph's such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies your child.
- "*Disclosure*" applies to activities outside of St. Joseph's, such as releasing, transferring, or providing access to information about your child to other parties.

II. Uses and Disclosures Requiring Authorization

St. Joseph's may use or disclose PHI for purposes outside of treatment, payment, and health care operations when appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when St. Joseph's is asked for information for purposes outside of treatment, payment and health care operations, St. Joseph's will obtain an authorization from you before releasing this information. St. Joseph's will also need to obtain an authorization before releasing your child's psychotherapy notes.

"Psychotherapy notes" are notes St. Joseph's therapists have made regarding a conversation which occurred during a private, group, joint, or family counseling session, which have been kept separate from the rest of your child's medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) St. Joseph's has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage/payment and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

St. Joseph's may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If staff know, or have reasonable cause to believe or suspect that a child has been abused or neglected, or if staff observe any child being subjected to conditions or circumstances that would reasonably result in abuse or neglect, St. Joseph's must immediately report it to the field or regional offices of the Wyoming Department of Family Services or local law enforcement agency, or cause a report to be made.

- **Adult and Domestic Abuse:** If staff have reasonable cause to believe that an elderly or disabled adult is being or has been abused, neglected, exploited, or abandoned, or is committing self-neglect, St. Joseph's is required by law to report such information immediately to a law enforcement agency or to the Wyoming Department of Family Services.

- **Health Oversight:** If you file a complaint against St. Joseph's with the Department of Family Services, St. Joseph's may disclose to them confidential mental health information that is relevant to that complaint.

- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about your child's diagnosis, treatment or the records thereof, such information is privileged under state law. St. Joseph's will not release such information without written authorization from you or your child's legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case**.**

- **Serious Threat to Health or Safety:** St. Joseph's shall not disclose any information communicated for the purpose of diagnosis, evaluation or treatment of any mental or emotional condition or disorder, in the absence of an express waiver of the privilege except where an immediate threat of physical violence against a readily identifiable victim is disclosed to St. Joseph's.

- **Worker's Compensation:** If you file a worker's compensation claim through your employer, this claim serves as a release of information for the duration of the benefit period, and upon request and upon notice to you, St. Joseph's must release mental health records pertaining to your injury to the Wyoming Worker's Compensation Division or your employer.

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ST. JOSEPH'S CHILDREN'S HOME
P.O. Box 1117 (307) 532-4197 (307)532-5921 Torrington, WY 82240
Fax: (307) 532-8405 or (307) 532-4024

IV. Patient's Rights and St. Joseph's Duties

Your Child's Rights Under the Federal Privacy Standard:

Although your child's mental health records are the physical property of the healthcare provider who completed it, in this case St. Joseph's Children's Home, you have certain rights with regard to the information contained in the record.

Parent or Guardian Rights:

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information about your child. However, St. Joseph's is not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may want to preserve confidentiality about your child's placement at St. Joseph's. Upon your request, St. Joseph's will send information regarding your child's treatment to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in St. Joseph's mental health and billing records used to make decisions about your child for as long as the PHI is maintained in the record. St. Joseph's may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, St. Joseph's will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. St. Joseph's may deny your request. On your request, St. Joseph's will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI regarding your child. On your request, St. Joseph's will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from St. Joseph's upon request, even if you have agreed to receive the notice electronically.

St. Joseph's Duties:

- St. Joseph's is required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- St. Joseph's reserves the right to change the privacy policies and practices described in this notice. Unless St. Joseph's notifies you of such changes, St. Joseph's is required to abide by the terms currently in effect.
- If St. Joseph's revises these policies and procedures during your child's treatment, St. Joseph's will mail a revised notice to you.

V. Complaints

If you are concerned that St. Joseph's has violated your child's privacy rights, or you disagree with a decision made about access to your child's records by St. Joseph's, you may contact the Clinical Records Technician at (307) 532-4197.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The Clinical Records Technician can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice is effective April 2, 2003.

St. Joseph's reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that St. Joseph's maintains. St. Joseph's will provide you with a revised notice by mail within 30 days.

Ronda Meyer

Interim Executive Director
St. Joseph's Children's Home

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CLOTHING and PERSONAL ITEMS

As a general rule, a child should have enough clothing for one week as he/she will do their own laundry each week.

- 1-2 pair shoes (tennis shoes)
- 5-6 pair of underwear
- 5-6 pair of socks
- 3-5 pair jeans/slacks
- 5-6 shirts
- Belt
- Sleeping attire. Pajamas, no nightgowns. Prefer gym type shorts and loose fitting top shirt
- 2-3 Sport Bras for girls. No bras allowed that contain an 'underwire' or snaps and hooks
- 1-2 pair of walking or gym shorts
- 1 Coat – Variable to weather for the time of year. Winter: Heavy coat, cap, gloves Summer: Light jacket
- Swim suit – One piece suits for girls

PERSONAL ITEMS: You may have personal items such as radios, stereos, games, and pictures in your possession providing behaviors are appropriate. They may be restricted and taken away if misused or behavior is placing you and/or others at risk. Items of high or of sentimental value should be left at home to prevent loss or damage.

Suggested personal items include: Hygiene items; small toys, such as hand games, Lego's; books (must be appropriate); Bible; favorite blanket or stuffed animal; radio; hat; CDs & player; etc. Music with sexual content, violence, or drug subjects is restricted.

The NEWELL CENTER is our secure and intensive unit for residents that demonstrate concerning levels of aggressive, disruption, harm to self, and other intense emotional issues. There are more restrictions regarding personal items on this unit.

RESIDENT DRESS AND GROOMING CODE

You should be neat, clean and modestly dressed at school, unit, or off campus activities. Footwear must be worn at all times and be safe and appropriate for activities in which residents are participating.

The following will not be allowed at St. Joseph's Children's Home:

- Ripped, heavily patched types of clothing, "baggies" and bandanas
- "Sagging" clothes or "low rider" jeans that are below the waist and exposing skin and/or underwear.
- Excessively short, tight or revealing clothing. Shirts should appropriately cover the shoulders and torso and fit under the arms. The torso should not be exposed any time. Shorts or skirts must be no shorter than **5 inches** above the knee
- Undergarments which are exposed
- Bras with an underwire, plastic or metal clips. Should be a "sports bra" only.
- Thong type undergarments
- Low cut shirts
- String or "spaghetti" strap shirts. Straps must be at least 3 inches wide
- Clothing or accessories which advertise drugs or alcohol, violence, Satanism, gangs, heavy metal rock groups, or any messages that could be offensive to others
- The staff retains the authority for the final decision of what is not appropriate

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Saint Joseph's Children's Home

1419 Main Street P.O. Box 1117 Torrington, WY 82240
Telephone# (307) 532-4197 Fax # (307) 532-8405

Medication Consent Form

Client Name _____ DOB _____/_____/_____

Prescribed medications at time of admission:

Medication	Dosage	Time(s)

I give permission for the above listed medication(s) to continue upon admission to St. Joseph's Children's Home. I give consent for medically indicated changes to dosage and administration time of medications. I will be contacted if a new medication is prescribed or if a medication is discontinued.

Parent/Guardian Signature _____ Date ____/____/____

Over-the-Counter (OTC) Medications:

	Initials		Initials
Acetaminophen (e.g. Tylenol)		Multi-vitamin	
Ibuprofen (e.g. Motrin)		Solarcaine Spray	
Cough Syrup (e.g. Robitussin DM)		Athlete's Foot Spray (e.g. Tinactin)	
Triple Antibiotic Cream (e.g. Neosporin)		Foot Powder	
Cough Drops (e.g. Sucrets)		Magnesium Hydroxide (e.g. Milk of Magnesia)	
Antacids – Antacids combinations (e.g. Maalox)		Anti-Diarrheal (e.g. Imodium AD)	
Saline Nasal Spray		Dyphenhydramine or Benophen (e.g. Benadryl)	
Antihistamine (e.g. Loratidine)		Epson Salts	
Hydrocortisone Cream			

I give permission for my child to receive any over-the-counter (OTC) medications as indicated above by my initials on this form. I understand that name brand or generic equivalent medications may be used.

Parent/Guardian Signature _____ Date ____/____/____

ST. JOSEPH'S CHILDREN'S HOME

THERAPEUTIC ANIMAL and 4H ANIMAL PROGRAM
PARTICIPATION WAIVER AND CONSENT

Resident Name: _____ Date of Birth: _____

Parent/Legal Guardian Name: _____

PURPOSE AND SCOPE St. Joseph's Children's Home utilizes approved therapeutic animals, including dogs and horses, as part of clinically supervised treatment services consistent with Wyoming Department of Family Services (DFS) and Joint Commission standards. Therapeutic animal activities may include animal-assisted interventions and equine-assisted learning or psychotherapy conducted under the direction of licensed clinical staff.

This waiver applies to therapeutic animal activities and St. Joseph's Children's Home 4-H animal program.

VOLUNTARY PARTICIPATION I understand that participation in therapeutic animal and 4-H animal program activities is voluntary. I further understand that participation is based on clinical determination of appropriateness and may be discontinued at any time by St. Joseph's Children's Home or withdrawn by me upon written notice.

ACKNOWLEDGEMENT OF INHERENT RISK I acknowledge and understand that activities involving animals, including dogs and horses, involve inherent risks. These risks may include, but are not limited to, allergic reactions, scratches, bites, falls, kicks, being stepped on, equipment failure, or other injuries to persons, animals, or property. I understand that equine-assisted activities in particular involve unique and unavoidable risks due to the size, strength, and unpredictable nature of horses.

Knowing and understanding these risks, I knowingly and voluntarily consent to my child's participation in therapeutic and 4-H animal activities at St. Joseph's Children's Home.

ANIMAL OWNERSHIP DISCLOSURE I understand and acknowledge that therapeutic animals used at St. Joseph's Children's Home are not owned by St. Joseph's Children's Home. Ownership of therapeutic animals remains with the individual owner, and St. Joseph's Children's Home does not assume ownership.

MEDICAL, ALLERGY, AND SAFETY DISCLOSURE I agree to inform St. Joseph's Children's Home, in writing when applicable, of any known allergies, asthma, fears, medical conditions, trauma history, behavioral concerns, or cultural considerations that may affect my child's safe participation in therapeutic animal activities. I understand that accurate disclosure is necessary to ensure appropriate clinical decision-making and risk mitigation.

RELEASE AND HOLD HARMLESS To the fullest extent permitted by Wyoming law, I hereby release, waive, discharge, and hold harmless St. Joseph's Children's Home, its administrators,

employees, agents, representatives, volunteers, and any other persons or organizations associated with therapeutic and 4-H animal services from any and all claims, demands, causes of action, or liability for injury, damage, or loss arising out of or related to participation in therapeutic and 4-H animal activities, including equine-assisted learning or psychotherapy, except in cases of gross negligence or willful misconduct.

I acknowledge that this release applies to injuries or damages resulting from the inherent risks of animal activities, including acts or omissions of animals, participants, or other individuals involved in the activity.

EMERGENCY MEDICAL AUTHORIZATION In the event of an emergency, I authorize St. Joseph's Children's Home to obtain emergency medical care for my child when reasonable efforts to contact me are unsuccessful. I understand that I am financially responsible for any medical services rendered.

ACKNOWLEDGEMENT AND SIGNATURE I acknowledge that I have read this waiver and consent form in its entirety, understand its contents, and have had the opportunity to ask questions. I sign this document knowingly and voluntarily on behalf of myself and my child.

ADDITIONAL INFORMATION FROM PARENT / LEGAL GUARDIAN Please outline any known allergies, medical conditions, trauma history, fear of animals, history of animal cruelty, or other information that may be relevant to your child's safe participation in therapeutic animal or 4-H/agricultural animal activities:

_____

_____

_____

_____

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_____

Parent/Legal Guardian Signature: _____ Date: _____

Printed Name: _____

Staff Witness Signature: _____ Date: _____

Printed Name / Title: _____